

Blepharoplasty & Brow Ptosis Repair

Origination: 06/16/09	Revised:	Annual Review: 12/15/11
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Purpose:

The Medical Technology Assessment Committee will review published scientific literature and information from appropriate government regulatory bodies (when available) related to Blepharoplasty and brow ptosis repair in order to determine inclusion in the benefit plan.

Recommendation:

A recommendation was made by the MTAC following discussion by committee members based on current literature:

Definition

- Blepharoplasty /Brow Ptosis repair is performed for either functional or cosmetic purposes.

Eligibility Criteria

- A. **Blepharoplasty** is a covered benefit due to functional impairment and the following criteria are met:
1. If the **primary indication is visual field obstruction**, **ALL** of the following criteria must be met:
 - a. Visual field obstruction by lid without taping that limits upper field to within 30 degrees of fixation and;
 - b. Visual field test with the eyelid taped shows improvement in the superior field of 10 degrees or more and;
 - c. A photograph of the patient looking straight ahead must be provided **OR**
 - d. If a Member meets these criteria (a, b,& c) in one (1) eye only and a bilateral blepharoplasty is planned, the opposite eye must have visual field obstruction without taping that limits upper field to within 40 degrees of fixation for both eyes to be covered;
 2. If the **primary indication is dermatochalasis**, then the above criteria also apply. In addition, a lateral photograph showing skin touching the eyelashes must be provided;
 3. *All other indications are not a covered benefit.*

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Recommendation, continued:

Eligibility Criteria, continued

- B. Brow Ptosis Repair is a covered benefit when **ALL** of the following criteria are met:
1. Visual field obstruction by brow without taping that limits upper field to within 30 degrees of fixation; **and**
 2. Visual field test with the brow taped shows improvement in the superior field of 10 degrees or more; **and**
 3. Photographs show the eyebrow below the supraorbital rim;
 4. *All other indications are not a covered benefit.*
- C. **Lower Lid Blepharoplasty** is a covered benefit when documentation is provided that indicates ectropion, entropion or trichiasis. *All other indications are not a covered benefit.*

References:

1. American Academy of Ophthalmology. Functional indications for upper and lower eyelid blepharoplasty. *Ophthalmology*. 1995;102(4):693-695.
2. American Society of Plastic and Reconstructive Surgeons. Blepharoplasty Position Paper. Arlington Heights, IL: American Society of Plastic and Reconstructive Surgeons, Inc.; October 1990.
3. American Optometric Association. Care of the patient with amblyopia. *Optometric Clinical Practice Guideline No. 4*. 2nd ed. St. Louis, MO: American Optometric Association; 1997.
4. American Academy of Ophthalmology. Laser blepharoplasty and skin resurfacing. *Ophthalmology*. 1998;105(11):2154-2159.
5. Dailey RA, Saulny SM. Current treatments for brow ptosis. *Curr Opin Ophthalmol*. 2003;14(5):260-266.

Disclaimer Information:

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Disclaimer Information, continued:

Blepharoplasty & Brow Ptosis Repair

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed Health Plans service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.